



Testimony to the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight

534 S. Kansas Ave, Suite 330, Topeka, Kansas 66603

Telephone: 785-234-4773 / Fax: 785-234-3189

www.acmhck.org

September 28, 2020

Madame Chairwoman and members of the Committee, my name is Kyle Kessler. I am the Executive Director for the Association of Community Mental Health Centers of Kansas, Inc. The Association represents all 26 licensed Community Mental Health Centers (CMHCs) in Kansas that provide behavioral health services in all 105 counties, 24-hours a day, seven days a week. In Kansas, CMHCs are the local Mental Health Authorities coordinating the delivery of publicly funded community-based mental health services. As part of licensing regulations, CMHCs are required to provide services to all Kansans needing them, regardless of their ability to pay. This makes the community mental health system the “safety net” for Kansans with mental health needs.

We appreciate the opportunity to provide testimony today. CMHCs around the state are inundated with demands as a result of the global pandemic. These range from trying to help alleviate the pressure on the state mental health hospitals to trying to help families with youth and adolescents who need crisis services.

The pandemic has triggered symptoms associated with anxiety and depression. The impact on the communities and employers in our state is substantial. One month ago, the Centers for Disease Control published a report in the *Morbidity and Mortality Weekly Report* that stated “the pandemic has been associated with mental health challenges related to the morbidity and mortality caused by the disease and to mitigation activities, including the impact of physical distancing and stay-at-home orders,” and that “symptoms of anxiety disorder and depressive disorder increased considerably in the United State during April-June of 2020, compared with the same period in 2019.”

We know that anxiety and depression are significant factors in lost workforce productivity. A little over a year ago, the World Health Organization published a report stating that “globally, an estimated 264 million people suffer from depression, one of the leading causes of disability, with many of these people also suffering from symptoms of anxiety,” and the study estimated that depression and anxiety disorders cost the global economy over a trillion dollars each year in lost productivity. The study further noted that, “Unemployment is a well-recognized risk factor for mental health problems, while returning to, or getting work is protective. A negative working environment may lead to physical and mental health problems, harmful use of substances or alcohol, absenteeism and lost productivity. Workplaces that promote mental health and support people with mental disorders are more likely to reduce absenteeism, increase productivity and benefit from associated economic gains.”

The CDC Report identifies some particularly concerning, albeit not surprising, statistical findings. These included higher levels of adverse mental health conditions, substance use, and suicidal ideation in June 2020. Nearly 41% of respondents reported at least one adverse mental or behavioral health condition including symptoms of anxiety disorder or depressive disorder; 31% had symptoms of a trauma or trauma related disorder related to the pandemic and 26.3% reported starting or increasing use of alcohol or substances. For context, “the prevalence of symptoms of anxiety disorder was approximately three times those reported in the second quarter of 2019, and prevalence of depressive disorder was approximately four times that reported in the second quarter of

2019.” Lastly, the report states, “Markedly elevated prevalences of reported adverse mental and behavioral health conditions associated with the COVID-19 pandemic highlight the broad impact of the pandemic and the need to prevent and treat these conditions.”

Policy recommendations that would assist CMHCs during and after the pandemic. Several issues have emerged that would assist CMHCs and other providers with doing their work. Some are as follows:

- **Approval by Medicaid at KDHE to allow therapy to be billed without patient present.** Medicaid Code 90846 would allow for billing therapy without the patient being present. Several states, like Texas and Iowa, allow this, and it is extremely valuable in treating youth or others who may have Medicaid while their parents, foster parents, or other caregivers do not. This allows for development and communication of treatment strategies, among other things, without discussing the patients in front of them, which many clinicians believe could result in triggering the patient, thus being counterproductive or even harmful. This would be considered cost neutral.
- **Continuation by Medicaid to allow telemedicine parity for treatment by telephone and televideo.** Telemedicine has been the gamechanger for behavioral health treatment during the pandemic. The Centers for Medicare and Medicaid Services (CMS) allowed more flexibility in treating patients than ever before. In areas of rural and frontier Kansas, telemedicine had been used in behavioral health with success for nearly two decades. Gaps, such as broadband and technology hardware, had been a barrier. However, the use of telephone has been a significant addition, and the ability to use telemedicine in urban areas has provided an additional access venue. We request the current policies be continued indefinitely and see this as a cost neutral proposal.
- **Increased Medicaid Rate Reimbursement.** With stagnant Medicaid rates and increased expectations, we have seen increased turnover in many of the professions we employ. The 2020 Legislature had increased rates by 2 percent before the Governor froze the increase as part of the allotments due to economic stability related to the pandemic.
- **Expansion of Medicaid.** More than half of those who present for treatment at CMHCs have no insurance. Expansion of Medicaid will provide coverage for those who have a mental illness or mental health issues, so they can access needed mental health treatment in their communities. We know that if a person with a mental health need does not have insurance, he or she is less likely to seek out care, which means that CMHCs oftentimes are dealing with crisis situations for those without insurance.

Thank you for the opportunity to appear before the Committee today, and I will stand for questions.